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Consent Under Constraint: Women's Accounts of Postpartum Contraceptive Governance in an Urban Village in Delhi

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Abstract: *India's fertility transition has brought national and state fertility below replacement level. However, official family-planning policy emphasizes contraceptive use as voluntary, informed and target free. Nevertheless, marginalized women's lived experiences frequently highlight pressure, a lack of complete information, and the dismissal of their refusals during postpartum contraceptive interactions. In this article, I explore this policy-practice tension, through a bounded qualitative case study examining the accounts of roughly 25 women from one low-income settlement in North-West Delhi. They reported having experienced coercive postpartum contraceptive encounters in public health facilities. Semi-structured interviews and small-group discussions conducted between September and November 2025 were interpreted alongside focused documentary analysis of demography reports and official family-planning guidance materials. Applying reproductive governance and epistemic injustice as sensitizing concepts, I found three mechanisms through which formal consent was undermined: refusal was eroded during a time of physical and institutional dependency, women experienced undisclosed or poorly explained postpartum IUD insertion and difficulty accessing removal, and providers engaged moralizing language that portrayed poor and migrant women' s fertility as irresponsible. The findings do not aim to measure prevalence of coercion or represent Delhi' s public hospitals. Instead, this purposively sampled set of accounts illuminates an implementation gap between rights-based policy and the everyday organization of care. These insights build on earlier recommendations for non-directive counselling; documentation of refusal alongside consent; accessible removal and follow-up pathways; and qualitative monitoring of women' s experiences alongside contraceptive-uptake indicators.*

Introduction

From a clinical standpoint, the postpartum period is considered an opportune time for contraceptive counselling. It is also notable that after childbirth, women are often in pain, fatigued,

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uncertain and rely more heavily on health care workers. But these conditions need not preclude informed choice. However, they make the time of counseling, its content, and its voluntary nature especially significant. For postpartum women, who rely on stretched out public resources and have few practical options and alternatives, institutional power and the urgency of health care needs may restrict the ability to say no or question a recommendation.

This issue exists in the context of altered demographic and policy landscape. India' s total fertility rate has fallen below replacement level, and Delhi' s rate is lower still (IIPS and ICF 2021; Office of the Registrar General of India 2023).Meanwhile, the Indian government has officially declared that its family-planning program is completely voluntary and without any targets, while all methods choices should be made by the patients (Ministry of Health and Family Welfare 2017).In addition, national guidelines for the provision of postpartum contraception also put emphasis on counseling and informed consent in Postpartum Intrauterine Device (PPIUCD) provision. The sociological question at hand is therefore not whether low fertility causes coercion to fall automatically. What we're looking at is the persistence of deep-seated population-control logics, standard operating procedures, and imbalanced clinical interactions in a program that, on the surface, upholds individual rights.

Existing literature details the decades-long process through which poverty, development, and women's fertility became entwined in Indian population policy thinking (Ravindran 1993; Hartmann 1995; Rao 2004; Connelly 2006; Ahluwalia 2008; Williams 2014; Sreenivas 2021). Other studies and rights reports have illuminated pressured consent, method-specific coercion, and low-quality care in family-planning service provision (Human Rights Watch 2012; Muttreja and Singh 2018). Research has paid less attention to women's own understanding of the micro-processes through which an ostensibly protected choice becomes constrained during postpartum encounters, especially in urban settings with low fertility.

In this article, I ask: (1) How do women experiencing coercive postpartum contraceptive visits narrate the undermining, sidestepping, or bargaining of consent? (2) What institutional and moral justifications recur in these narratives? And (3) how can these encounters help us understand the disconnect between rights-based policy texts and PPIUCD care on the ground? The analysis below is not meant to make claims about prevalence. By focusing on Delhi as a bounded critical case, I hope to shed light on possible dynamics of reproductive governance that can extend beyond the official demographic agenda, and can emerge, even in contexts where women know their rights.

Reproductive Governance in a Low Fertility Rights-Based Policy Context

From Population Control to Reproductive Governance

In India today, reproductive governance is characterized by the government's intensive intervention in women's reproduction. It needs to be understood as part of a wider historical pattern that was shaped by colonial concerns, neo-Malthusianism, postcolonial development policies and gendered hierarchies. As explained by Morgan and Roberts in their study of reproductive governance (2012), it is clear how political institutions and other actors use such strategies such as moral persuasion and coercion to influence reproductive choices of women. Historically, what has been observed is that these practices have been enacted on the bodies of the marginalized women. This has given rise to a complex system where reproductive autonomy has come to be shaped by the state's demographical agenda.

The historical origins of this demographic logic can be found in the latter half of the nineteenth century, when British administrators and social reformers attributed poverty and famine to "overpopulation" and it was seen as a hindrance to the benefits promised by colonial modernity. Under the influence of Neo-Malthusianism, contraception emerged as an instrument of demographic management rather than as a reproductive choice (Ahluwalia, 2008). As Ahluwalia and Parmar (2016) suggest, discussion on birth control during the colonial period did not present Indian women as independent actors but as entities in need of regulation, thus inscribing the birth control discourse into mechanisms of social reproduction. The Western birth control activists saw the countries in the Global South, like India, as a testing ground for experimental contraceptives, reflecting imperial imaginaries that treated racialized and poor women as suitable recipients of technologies which were not yet deemed safe for use elsewhere (Ahluwalia, 2008).

In the post-independence period, these issues were further institutionalized in India's family planning program. By the 1960s, population control came to be closely linked to developmental planning, and policy makers and international agencies began to see the reduction of fertility as an important

aspect of economic growth and modernization (Coale & Hoover, 1958). This led target-driven family planning programs and sterilization incentives to become a mainstay of the policy apparatus. Demographic fears persisted in the discourse even as subsequent scholarship challenged the causal link between high fertility and underdevelopment, instead locating it in poverty, inequality and limited access to healthcare and education (Birdsall, 1989; Caldwell, 1982; Hodges, 2004; Sen, 1994).

The family planning programs that took place during the Emergency must also be seen in light of this larger framework. These were legitimized as "poverty eradication" and "national development" measures (Williams, 2014). However, as Vicziany (1982) suggests, the coercive nature of the program was not a result of the Emergency but rather the government tried to institutionalize and intensify existing policies that were having a disproportionate impact on the poor and marginalized population groups.While the excesses of the Emergency have certainly been subject to great criticism, demographic logics have certainly played a role in the framing of reproductive policies in India. The reports of coercive practices in sterilization camps, inadequate counselling and compromised consent data (Human Rights Watch, 2012) also highlights the gendered nature of contraceptive responsibility, with female sterilization rates being alarmingly higher than male sterilization rates.

The maternity ward's role in contraceptive provision has grown significantly in recent years, stemming from the fact that pregnancy and childbirth necessitate ongoing contact with governmental healthcare systems. Rights groups and media outlets have documented claims that women received IUDs without their full consent in Delhi and in other states (Human Rights Watch 2012; Times of India 2024). These reports do not establish prevalence, but they make postpartum consent an important empirical and policy question.

Population growth data and discussions around IUD uptake both take place amid sharp declines in fertility. India' total fertility rate dipped to 1.9 in SRS 2023, already below replacement level of 2.1 children per woman, with Delhi' at 1.2 (Office of the Registrar General of India 2023). This is also echoed in NFHS-5 with Delhi having a sub-replacement fertility rate (IIPS and ICF 2021).This does not reduce women's desire to avoid or postpone additional childbearing; in fact, it emphasizes the need for such decisions for women who may have had an unplanned pregnancy if they had not taken precautions. But this does call into question more general statements about a population crisis and shows the need to be concerned with how women's desires shape service provision.

Delhi can be viewed, therefore, not as a typical, but instead a critical case study and not a reflection of trends across the country. The interplay of fertility trends and socioeconomic indicators allows the analysis of the ways in which population control ideology may remain in collective and institutional consciousness even while central messages shift to voluntary family planning, as a way of promoting women's rights. As revealed by the women's narratives in the interviews, these seemingly contradictory desires are lived locally, and when examined in isolation are not enough to determine citywide prevalence.

Fromal Policy Commitments and the Implementation Gap

Reproductive governance refers to the processes through which reproductive behavior is shaped by law, policy, discourse, surveillance, inducement and coercion, and is the concern of states, organisations, professional actors and moral discourse (Morgan and Roberts 2012).This takes analysis beyond a false dichotomy in which signing a form is equated with voluntariness and absence of physical force is equated with choice. Consent is relational, it is created in unequal relations with regards to information, authority, time, bodily security and access to other possibilities (Petchesky 1984, Dixon-Mueller 1993).

The formal policy position of the Indian government sets a benchmark for comparison to the accounts of the participants. According to the Ministry of Health and Family Welfare, the Indian family-planning program is free from any targets and completely voluntary and clients have the right to choose the right method of contraception (Ministry of Health and Family Welfare 2017).Guidance documents for the official postpartum-IUCD programme recommend obtaining informed consent including provision of benefits, limitations, side effects, insertion and removal. The Indian commitments for FP2030 also highlight access, quality counselling, method choice and targeting marginalized groups. (Government of India 2022).

These commitments are, however, not a blueprint for the operation of all facilities. The interview narratives also do not prove to be evidence of an institutional policy across the city. The key idea of the

analysis stems from the difference between these official requirements and the personal experience of the participants themselves. Monitoring for performance may be accompanied by a stated denial of numerical targets, and standardized workflows may include an expectation that women take an offered method, without a coercive directive. For these reasons, documentary analysis is employed as contextual evidence, and a normative point of comparison, and not as "proof" that a specific provider worked under a specific target.

Delhi as a Critical Case Study

Delhi as a city is analytically advantageous due to its low level of fertility and the high reliance of the economically disadvantaged communities on public maternity care, as well as the high influx of migrants. In Delhi, the total fertility rate stands at 1.2, a stark contrast to India's national average of 1.9; specifically, rural and urban figures for Delhi are 1.3 and 1.2, while India's are 2.1 and 1.5, respectively (Office of the Registrar General of India 2023). These statistics do not capture coercion. But they document that women's experiences took place in a city where a broad assertion of demographic crisis is difficult to make.

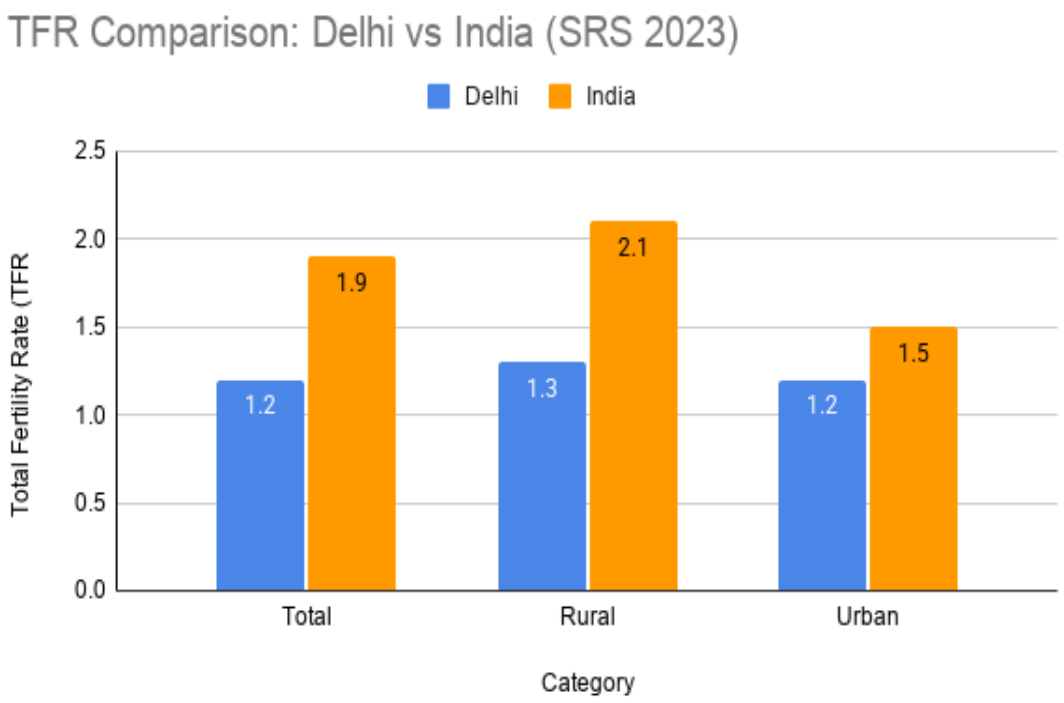

Figure 1: Total Fertility Rate (TFR) in India and Delhi (SRS 2023)

Materials and Methods

- **Design and Evidentiary Scope**

The research adopted a bounded qualitative case study approach, drawing on both Participatory Action Research (PAR) and feminist methodology. Interview questions were co-developed with one participant. Participants engaged as active researchers through small-group discussion, collective interrogation of personal experiences, and drafting recommendations for change related to contraceptive counselling, respect for refusal, communication about alternatives, and complaint and redress mechanisms. A patient-rights flyer was shared as a reciprocal dissemination and knowledge-sharing activity. The empirical corpus includes semi-structured interviews and small-group discussions which were interpreted in relation to focused documentary analysis of national demographic reports and family-planning policy statements.

- **Site, Participants and Recruitment**

Even though the sample wasn't designed for prevalence figures or statistical generalization, its analytical soundness can be explained by the notion of information power. Even with a limited number of participants, qualitative studies can yield considerable insight if the research focus is precise, individuals involved have lived experience, interviews are deeply informative, and the analysis is grounded in theory. (Malterud et al. 2016). Interviews were information-rich as all participants had firsthand experience with postpartum contraceptive encounters in public health facilities. Additionally, the participants provided rich, detailed accounts that directly addressed the specific research inquiries.

Data collection was conducted between September and November 2025 in a single low-income settlement in North-West Delhi. Around 25 women were involved. Most participants were in their twenties or thirties; many were domestic workers, street vendors, or home-based workers, while others did unpaid domestic labour. Large numbers were first- or second-generation migrants and depended on public facilities for maternal health services.

Snowball sampling recruited women who described having experienced coercive postpartum contraceptive methods in public facilities. This criterion intentionally produced an information-rich sample of adverse encounters. This method, however, prevents us from quantifying the frequency of coercion, drawing comparisons between women subjected to pressure and those not, or making claims about all users in any given facility, district, or Delhi overall. To keep participants from being identified, the settlement where the study was conducted remains unnamed. Interviews were conducted at the house of one of the participants. Women felt safe in this space and described it as a comfortable environment.

- **Data Collection and Analysis**

Guided by a semi-structured questionnaire, interviews addressed topics of childbirth, postpartum counselling, consent discussions, contraception method-preference, side effects, follow-up care, involvement of family members, and pushback against perceived pressure. Focus group discussions were sometimes convened following interviews, allowing participants to reflect on their commonalities and differences of experience. Interviews were carried out in Hindi since it was the language participants were most comfortable with. Each interview took around 45–50 minutes. Audio recordings were taken wherever possible after obtaining consent from the participants. In instances where participants did not feel comfortable talking in front of the recorder and were self-conscious, notes were taken. The gathered interviews and notes were then transcribed and afterward translated to English for analysis.

The approach to the analysis was inductive and thematic. The interviews were scoured for recurring themes concerning how consent was sought and refusals managed, what information was shared or kept back, family members' involvement in decision-making, and women's responses to pressure from the institution. Reproductive governance and epistemic injustice were subsequently employed as sensitizing concepts to illuminate the connection between these patterns and the policy context. This analysis is careful to note the difference between what study participants report experienced versus medically attributed and independently verified clinical fact.

- **Documentary Analysis**

The documentary review was limited purposively to materials needed to understand the case context: NFHS-5 (2019–20 21), the SRS Statistical Report 2022, the Government of India' statement that family planning is target free and voluntary, national postpartum- IUCD guidance, and India' commitments for FP2030. Documents were analyzed for: (a) fertility levels and contraceptive prevalence; (b) official definitions of voluntariness, informed choice, and quality; and (c) which agency leads postpartum contraception. The documentary evidence offers a policy framework, rather than a direct assessment of how programs function within the hospitals the participants described.

- **Ethics and Reflexivity**

Participants were told about the nature of the study, that participation was voluntary, and that they could withdraw at any time. The name of the settlement where the participants resided has been redacted for privacy. Throughout data collection and analysis, I was conscious of differences in social position and access between myself and participants.

Limitations

Four limitations should be noted about the claims made in this paper. First, purposive snowball recruitment among women recruited on the basis of having reported coercion prevents calculation of prevalence and introduces network and selection biases. Second, because all participants were from one settlement, findings can only be transferred to settings with similar contextual conditions, not generalized as statistically representative. Third, recall may be influenced by time and intervening health experiences. Fourth, lack of provider participants, administrators, hospital records, and observation limits inferences about provider intent and clinical causation and precludes calculation of incidence at the facility-level. These do not discredit participants' accounts. Rather, they delimit what this study can show: recurring mechanisms and meanings across a limited range of reported experiences.

Findings

- **Eroding Refusal through Dependency and Procedural Consent**

One of the most important themes that emerged in the interviews dealt with how consent took on the garb of a procedural formality instead of being an expression of choice. When women expressed concerns about whether a particular device would be suitable for them, or complained about adverse reactions, their concerns were treated as issues to be solved, not limits that were to be respected. Counselling thus turned into a process of gaining agreement instead of offering information that could help in decision making. The following narratives of women detail how women who tried to resist and negotiate their way around contraceptive pressures were treated and how their consent was ultimately mediated through institutional power, relational vulnerabilities, and bureaucratic procedure.

Seema, a mother of three and a domestic worker in his mid-thirties, explained how she had a severe allergic reaction to Copper-T in the past, which had caused her prolonged menstrual bleeding and an infection, yet despite this she was coerced into adopting the device after giving birth. She remembered the maternity ward was overcrowded, and that "two or three patients were on each bed." There were no beds available in the delivery room, so she lay on the floor, " the floor was cold…but the pain was unbearable, so it didn't matter." After giving birth, she repeatedly explained that the device "did not suit her," but her concerns were dismissed. Instead, she was mocked for having "so many children" and warned that she would not be allowed to see her newborn unless she agreed. When she continued to refuse. She was told, "if you don't want to get a Copper-T, then go and sit there." She recalled how after witnessing this exchange, the other women in labour fell silent and complied without protest. The doctors pointed this out to her, remarking that none of the other women were objecting.

Exhausted, separated from her baby, and facing pressure from both the hospital staff and her family members who had been misinformed about her refusal, she eventually caved. The same symptoms reoccurred months later and she eventually had to have the device removed at a private clinic. Her account illustrates when consent is offered during duress, refusal turns into a boundary to be torn down.

While Seema's experience illustrates how refusal is eroded through exhaustion and isolation, Pooja's account reveals how consent can also be manufactured through fear, deception, and the strategic mobilization of family members. Many times, what appears to be consensual agreement in postpartum environments is actually a product of a number of institutional factors that limit choice. Pooja, a migrant from Himachal Pradesh who lives in Delhi, described how her unfamiliarity with institutional childbirth shaped her vulnerability within the public healthcare system. Her first child had been born at home because her family was unable to take her to the hospital. During her second pregnancy, she was admitted at a government hospital after experiencing prolonged labour pains. While she was there, she witnessed other women like her being slapped and shamed for expressing pain. She overheard a remark directed towards a woman in labour, "if you were going to experience pain, then why did you do this with your husband? Weren't you embarrassed to do it?" Afraid of similar treatment, she suffered in silence.

Shortly after giving birth, Pooja was asked to sign a consent form while she was still distressed from her experience in the maternity ward, including witnessing her newborn being bitten by a rat in the hospital nursery. When she asked what the form was for, she was told she "had to get a Copper-T." She refused, but the staff then turned to her husband, falsely informing him that she had changed her mind. Unsure of how to challenge medical authority, he eventually signed the form. Once she received the documents back from them, she felt confused and betrayed. It later turned out that both of them had been misled.

Following her delivery, she began to experience severe abdominal pain and copious amounts of bleeding. Her concerns, of course, took the same path as most: she was treated dismissively in the public healthcare system and finally recognized by a private practitioner, who blamed the symptoms on an infection from the device. Ruminating on the experience, she recalled asking repeatedly, "But why does it have to be now?" to which the healthcare worker responded "it is non-negotiable."Pooja's story highlights the pressures migrant women face in engaging with very different and often frightening clinical procedures, within a system that is overcrowded and over-exerted and that seems more invested in maintaining the outward rituals of informed consent. Even in cases where these women explicitly expressed contraceptive preferences and prior adverse experiences, their knowledge was routinely ignored in favor of institutional authority, with the clinical relationship characterized as a hierarchical, shaped by epistemic inequality.

- **Undisclosed Insertions and Constrained Removal**

In my interviews I came across a small but deeply consequential set of narratives which revealed the long-lasting aftereffects of postpartum interventions carried out without women's full knowledge or informed consent. These accounts show how the insertion of IUDs remained undisclosed and how it was only later on that they were discovered either accidentally or through medical investigations undertaken for unrelated concerns or for conceiving difficulties.

One such case is that of Ganga, a household help, who learned about the presence of a Copper-T in her body almost a decade after giving birth. At the time of her delivery, neither her nor her family were informed about it. A few years later, when Ganga and her husband started to plan their second pregnancy, they were unable to conceive. So, they sought the help of relatives, traditional healers, temple priests, and doctors, but nothing helped. They only found out about the presence of an IUD after a diagnostic scan. Ganga was shocked. She had believed there was something wrong with her and had internalized the blame for her inability to conceive. She had felt inadequate in the eyes of her family because of a device that had silently and invisibly structured her reproductive life for years. Even though the IUD was eventually removed, she could never really let go of the psychological torment and suffering it had caused her. She said, "maybe if they had said something, if they had at least told me about it."She not only expressed her grief, but a sense of loss that she was not consulted about such an intimate decision.

Deepika, a first-time mother, came to Delhi from Bihar after marrying at the age of twenty-one and had a similar experience. She said that she came to know about the insertion of Copper T after she came back from the hospital. After giving birth, Deepika started feeling discomfort, which felt like "something was scraping from inside." One day, while using the restroom, she felt a thin thread and was alarmed. Unsure of what it was, she turned to her mother-in-law, who in turn spoke to some relatives living in another part of the city. Some of these women had themselves been inserted with IUDs postpartum, and it was through their familiarity that they were able to identify what it was.

When she returned to the hospital requesting the device to be removed, she was told that it could not be taken out before five years, and she was advised "not to have a child" during that time. Unaware that the insertion had even taken place and faced with resistance from hospital staff, she endured the discomfort for nearly three years before having the device removed from a private clinic. Reflecting on her experience, she said that as a first-time mother, she had no idea such a procedure could be carried out without her knowledge. Deepika's story throws light on how common postpartum IUD insertions have become within some communities, such that women have come to rely on informal networks to understand what has been done to their bodies. Seen in this way postpartum devices become an invisible force shaping reproductive futures, causing physical discomfort, and altering a woman's everyday life far beyond the moment of childbirth.

- **Demographic Stereotyping, Sexual Shame, and Epistemic Hierarchy**

Another common theme that was observed in the accounts of the participants was the use of moral judgment, shaming language and demographic stereotyping by health care providers. Clinical interactions tended to veer into the terrain of moral policing. A number of participants recounted comments about how their suffering during childbirth was because of their sexual culpability. There was an implication that they "should be able to bear the pain of childbirth if they can enjoy sex." Such statements position pregnancy and delivery as punitive events. They also suggest that women's sexual lives disqualify them from accessing proper care and expecting compassion in clinical interactions. By

framing postpartum pain and coercive contraceptive intervention as an inevitable price for sexual relations, what these interactions do is reproduce heteronormative expectations of feminine endurance. Moreover, they obscure the right to dignified maternal care, and implicitly legitimize the diminishment of a woman's consent.

In the interviews participants also shared experiences of being told, "You already have two kids. "How many more kids will you have?" "People like you give birth to four to five kids." Comments such as these are reminiscent of the long history of the population control discourse in India, which treats the fertility of poor, migrant and minority women as excessive and problematic. To comprehend how women's bodies become sites through which population anxieties are managed and national futures are imagined Foucault's idea of biopolitics is significant (Foucault, 1978). The scholarship of feminist historians has shown how the family planning discourse has long been guided by neo-Malthusian fears (Ahluwalia, 2008; Ahluwalia and Parmar, 2016.) These fears position the reproductive capacity of poor and marginalized communities as something that would threaten economic development. These accounts also echo Hartmann's (1995) observation that population control programs frequently portray the reproductive choices of marginalized women as troublesome, thereby legitimizing the use of coercion as being in the interest of society. The moralizing comments made to the participants are not simply professional lapses but they are part of a policy history which has relegated certain sections of the population as demographically burdensome.

- **Endurance, Negotiation, and Everyday Resistance**

Despite the participants describing their experiences as a type of pressure and institutional power imbalance, they did not depict themselves as passive victims of contraceptive practices. Some women were already using other methods to manage their fertility prior to arrival on the maternity ward. A few wanted to space pregnancies and reported condom or injectable use while others had completed their families due to limited household resources. Refusal of a PPIUCD insertion was therefore not always indicative of contraceptive opposition. In many instances, it reflected a knowledgeable preference for another method, concern based on past negative experiences, or the desire to remain autonomous in deciding when and how contraception would be used.

Women demonstrated their agency not just through refusal but also by questioning health workers about the necessity of immediate postpartum contraceptive insertion, detailing prior contraceptive history, expressing their desires, enlisting family backing, and seeking counsel from other women when guidance from medical staff was insufficient. Women experiencing post-insertion pain or other issues frequently sought follow-up care or removal, with some eventually turning to private clinics after feeling ignored by public health services. Taken together, these actions suggest that participants continued to evaluate their situation and strive toward their reproductive goals even when their decision-making was institutionally limited.

Agency was also expressed through strategic endurance. "Sarkari hai toh jhelna padta hai"—"it is a government hospital, so one has to endure it"—was a sentiment that reflected participants' awareness of their reliance on public facilities and the repercussions of speaking back to health-care personnel. Silence or deferred agreement should therefore not be equated with consent. Instead, this strategy may have been a deliberate response to pain, fatigue, fear of receiving poorer treatment in the future, concern for their newborns, or reliance on staff for receiving their discharge papers and return visits. Administrative records of patient acceptance may therefore conceal disagreement, coerced resignation, or efforts to prevent further harm.

Through small-group discussions, participants found another avenue to express their agency. Upon learning that others had experienced similar problems, participants discovered that incidents they had previously conceived of as individual failings or isolated events were widely shared by women. They recognized common problems and collectively voiced their priorities for change. They articulated the needto receive counselling at an earlier stage in pregnancy along with the importance of being provided within formation about a variety of contraceptive methods so that they can make appropriate decisions based on their individual needs. They also stressed on the need for easier access to removal services, especially in cases where the device did not suit a particular individual. They also collectively highlighted the importance of a confidential complaint redressal mechanism. All these responses taken together indicate that the issue did not lie in women's lack of knowledge or capacity with regard to fertility

management. Rather, it was their unequal power to act on what they know, prefer, and say no to within institutions that claim to support their autonomy.

Discussion

Based on these experiences, three overlapping mechanisms that narrowed consent were identified. First, women's bodily and institutional reliance during childbirth discouraged refusal: Women said they were separated from their infants, were ridiculed, and expected to take everything in their stride without complaining. Second, documentary consent could be extracted without meaningful authorization, including through partial disclosure or spousal authorization. Third, preconceived notions about women's socio-economic background, migration status, sexuality, and fertility rendered the women's perception of their body and their own contraceptive desires insignificant.

Hence, these results suggest a more complex view of the demographic paradox underlying the study. Low fertility rates do not imply that women are not in need of or do not want contraception. But when women are provided with postpartum family-planning services voluntarily and with real choice, it can help them to achieve their reproductive goals. The focus shouldn't be on whether a PPIUCD is available, but when an available option becomes the expected choice. The focus shouldn't be on whether a PPIUCD is available, but when an available option becomes the expected option. The women's narratives indicate that despite the fact that the target-based approach to contraceptive use has been abandoned by national policy and the formal principle of informed decision-making is now in place, institutional practices are still shaped by the old presupposition that it is mainly marginalized women's fertility that needs to be controlled.

This is not necessarily evidence of current state policy of coercion, but a policy-practice gap. When all these accounts are combined, it is clear that there are discrepancies between the rights that are promised in policy and the lived experiences of women receiving contraceptive care.While they do not depict coercion as a conscious strategy of the state; instead, they show how autonomy is limited in everyday clinical interactions. A signed consent form may meet institutional requirements but gives no indication if a woman understood her choices, felt free to refuse, or if there were meaningful alternatives available to her. This gap can be understood through the lens of reproductive governance, which focuses on more hidden forms of power that emerge and coalesce through clinical practices, medical expertise, moral framing, and differential access to contraceptive options.

These narratives reveal instances of epistemic injustice within particular clinical settings. When participants mentioned previous allergic reactions to contraceptives, abdominal pain, wanting children, or other contraceptive alternatives, these were all dismissed without further consideration. This denial of credibility has real ramifications – even if the approach that clinicians advocated was medically sound. Respectful ethical counselling involves recognition of women as knowers and decision makers, even if they reject a method that is suggested to them.

The bounded nature of this research design facilitates analytic generalization, not statistical. Mechanisms identified in this context (coercion-dependency, proceduralized consent, familial authorization, method-specific pressure, moral notions of fertility) present propositions which can be examined with data from other facilities and regions. Future studies must include women's accounts who did not face coercion, provider interviews, and observations, medical records, and grievance protocols for understanding distribution, discrepancy and organizational determinants of postpartum coercion.

Policy Implications

The cases presented here illustrate the need to conceptualize contraceptive counselling as a process rather than a one-off interaction, beginning at the earliest opportunity, if possible during the prenatal period and extending into the postnatal period. Women ought not to be put in the position of deciding on contraception for the very first time when they are actively in labor, in pain, or healing from delivery. Counselling should be non-directive and cover all options, including living without contraception. Women should be told about potential side-effects as well as follow-up care and removal and should be assured that they will continue to receive quality care even if they refuse a method.

A signature is simply not enough to determine whether a person gave informed consent. Documentation in clinical notes must include the timing of the counseling sessions, the various types of contraception that were considered and finally the informed consent of the patient. Counselling should also give details on how and where the method can be removed. Regular discussions with patients

regarding their experiences, as well as a confidential and readily available complaints procedure, could identify pressures not apparent from contraceptive uptake statistics.

In the event that women experience pain, discomfort or other complications after insertion, they should have access to clear, affordable and respectful pathways for follow up care and removal. These services should focus on women's well-being and concerns rather than simply encouraging them to continue using the method. The information should also be transmitted in languages spoken locally and in ways that women can understand.

It was also observed during the interviews that many women were already actively managing their fertility, some of them also expressed their desire to space their pregnancies and described using alternative methods such as condoms or injectables, others expressed that they had limited resources, so they did not wish to have large families. Nonetheless, they found themselves being framed as irresponsible reproducers, having the ability to choose for themselves being stripped away from them.Healthcare providers need to be sensitized to understand women's reproductive strategies and not presume non-use of contraceptives. Counselling guidelines should recognize that women may not want to use a specific method and that they are informed about alternate methods of fertility management. This transition would help facilitate greater decisional autonomy.

Most importantly, reproductive health frameworks should recognize the fact that marginalized women are not "passive patients" (Subramani, 2025) but active agents who are capable of reasoning, negotiating and making decisions on their own based on their lived experiences. While women make reproductive choices within social, economic and cultural boundaries, these should not be seen as proof of restricted capacity for informed consent. Instead, as these interviews illustrate, women evaluate their situations, consider their choices, and seek to achieve what is important to them and what constitutes a good life for them. These pressures, therefore, do not justify overruling choice, but rather provide a rationale for facilitating it; informed choice increases women's autonomy even in limited environments – and should be at the heart of any moral framework for reproductive policy.

Conclusion

The results of this bounded case study cannot be extrapolated to suggest the prevalence of postpartum contraceptive coercion in Delhi but it can however demonstrate the way in which coercion was experienced by the women interviewed, and the way in which they understood the conscription of their consent, as well as how their testimonies expose a tension between the discourse of rights and the realities of clinical practice. What is happening, then, is by no means the continuation of a clear population-control mandate. It is the afterlife of demographic governance in organizational habits, unequal credibility, and procedural forms of consent. A rights-based response must preserve access to postpartum contraception while making refusal practically safe, removal accessible, and women's knowledge consequential.

Informed Consent Statement

Informed consent was obtained from all study participants. This article does not include any identifying information; all participant names are pseudonyms, and the study location is not disclosed.

Data Availability Statement

However, the data that have been collected through the interview for the purpose of this study are not available in public domain in order to ensure the confidentiality of the participants. However, de-identified quotations other than those mentioned in the paper can be made available by the authors upon request. The demographic and program data referred in the paper are available in public domain through the references provided below.

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Conflicts of Interest

The author declares no conflict of interest.

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